**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

SANJAY KHANDUJA, MD
3100 TIMMONS LANE, STE 250
AUSTIN, TX 77027

**Respondent Name**

METROPOLITAN TRANSIT AUTHORITY

**Carrier's Austin Representative Box**

Box Number 19

**MFDR Tracking Number**

M4-11-4159-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

**Amount in Dispute:** $150.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The carrier asserts that it has paid accordingly to applicable fee guidelines."

**Response Submitted by:** Metro c/o Flahive, Ogden & Latson, P.O. Box 201329, Austin, TX 78720

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 26, 2011 | 99456-W5-WP | $150.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated June 01, 2011
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - Musculoskeletal body areas are defined as follows: spine and pelvis; upper extremities and hands; and lower extremities (including feet). Lumbar, thoracic and bilateral hips are one body area. $350 MMI plus $300 for spine and pelvis equals $650.00. When multiple IRs are required as a component of a designated doctor examination, the designated doctor shall bill for the number of body areas rated and be reimbursed $50.00 for each additional IR calculation.

   Explanation of benefits dated June 20, 2011
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - Musculoskeletal body areas are defined as follows: spine and pelvis; upper extremities and hands; and lower extremities (including feet). Lumbar, thoracic and bilateral hips are one body area. $350 MMI plus $300 for spine and pelvis equals $650.00. When multiple IRs are required as a component of a designated doctor examination, the designated doctor shall bill for the number of body areas rated and be reimbursed $50.00 for each additional IR calculation.

**Issues**

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

**Findings**

1. The requestor billed $800.00 using CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR. Review of the documentation supports that MMI was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(i)(I), lumbar, cervical, thoracic and pelvis/hip are part of one body area, the spine. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category III method on the lumbar and Category I on the thoracic and the bilateral hips (spinal region) is $150.00. The combined MAR for the MMI/IR areas is $500.00.
2. Per the EOB comments, the respondent has chosen to reimburse the range of motion for $300.00 for the hips with the MMI for the combined amount of $650.00 for the disputed CPT code 99456-W5-WP. Additional reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | February 27, 2012<br>Date |
|---|---|---|

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.